

 Fax

To: Park Compounding
Fax: 949-551-1950 Phone: 858-704-4644
From: _____
Fax: _____
Phone: _____

Number of Pages: _____ Date: _____

Comments: _____

- PROTECTED HEALTH INFORMATION
- BUSINESS CONFIDENTIAL INFORMATION

This fax is intended only for the exclusive use of the addressee(s), and may contain privileged or confidential information. If you are not the intended recipient, or the person responsible for delivering the fax to the intended recipient, be advised you have received this fax in error and that use, dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this fax in error, please destroy the attached document(s) and immediately notify the sender of the error.

Please deliver to: _____ with this cover sheet to protect its contents.

Order Date: ____/____/____ **Earliest Date To Be Administered:** ____/____/____

Please allow for 72-hours turnaround time (3 business days) before order will ship. Incomplete order submissions may delay processing.

Physician Information Required

Prescribing Physician: _____

DEA: _____ NPI#: _____

Center/Clinic: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

Primary Contact: _____

Email: _____

Center/Clinic May Receive Shipments on Fridays: YES NO

***If multiple prescribing physicians, use separate order form for each.**

Patient Information Required

Patient Name: _____

Birthdate: ____/____/____ Phone: (____) _____

Address: _____

Known Drug Allergies: _____

No Known Drug Allergies (NKDA)

Patient Profile(s) or Block Schedule Attached: YES NO

of Patients*: _____

Paid by: Physician/Clinic Patient

Ship to: Physician/Clinic Patient

Medication Orders		If you need a medication not listed, please contact us at 858-704-4644			
Medication	Strength or Concentration	Size/Volume	Instructions for use	Quantity	# Refills
<input type="checkbox"/> Pred-Moxi (Prednisolone acetate and moxifloxacin hydrochloride)	(1/0.5)%** <i>alternate</i> _____	<input type="checkbox"/> 3mL or 6mL dropper	Instill into the affected eye(s) following the instructions provided by your prescriber		
<input type="checkbox"/> Pred-Ketor (Prednisolone acetate and ketorolac tromethamine)	(1/0.4)%** <i>alternate</i> _____	<input type="checkbox"/> 3mL or 6mL dropper	Instill into the affected eye(s) following the instructions provided by your prescriber		
<input type="checkbox"/> Pred-Moxi-Ketor (Prednisolone acetate, moxifloxacin hydrochloride and ketorolac tromethamine)	(1/0.5/0.4)%** <i>alternate</i> _____	<input type="checkbox"/> 3mL or 6mL dropper	Instill into the affected eye(s) following the instructions provided by your prescriber		
<input type="checkbox"/>	<i>alternate</i> _____				

*Prescribers are reminded that state law allows patients to receive medications from a pharmacy of their choice
**Representative formulation. Customizable within certain ranges. Please contact the pharmacist to discuss.

REMINDER: Please check patient information has been included for all medications before submitting

Order Submission

THIS FORM CONSTITUTES A PHYSICIAN'S ORDER/PRESCRIPTION WHEN SIGNED BY THE PHYSICIAN

Please FAX with cover sheet to Park Compounding **949-551-1950**

Authorized Physician's Signature
X _____

Please allow for 72-hours turnaround time (3 business days) before order will ship. Incomplete order submissions may delay processing.

of Prescriptions _____

Payment Information

IF NO CREDIT CARD ON FILE AND YOU ARE NOT CURRENTLY BEING INVOICED, PLEASE SUBMIT THE FOLLOWING:

Credit Card Number: _____ Expiration: ____/____ CVC Code: _____ Billing Zip: _____

This form is provided in an effort to improve patient safety.

Patient Information

First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA <input type="checkbox"/>
<input type="checkbox"/> Ship to Patient <input type="checkbox"/> Ship to Clinic	Rx Start Date:	Number of Refills:	Paid by: <input type="checkbox"/> Physician/Clinic <input type="checkbox"/> Patient	
Credit Card Number: _____ Expiration: ____/____ CVC Code: _____ Billing Zip: _____				
First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA <input type="checkbox"/>
<input type="checkbox"/> Ship to Patient <input type="checkbox"/> Ship to Clinic	Rx Start Date:	Number of Refills:	Paid by: <input type="checkbox"/> Physician/Clinic <input type="checkbox"/> Patient	
Credit Card Number: _____ Expiration: ____/____ CVC Code: _____ Billing Zip: _____				
First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA <input type="checkbox"/>
<input type="checkbox"/> Ship to Patient <input type="checkbox"/> Ship to Clinic	Rx Start Date:	Number of Refills:	Paid by: <input type="checkbox"/> Physician/Clinic <input type="checkbox"/> Patient	
Credit Card Number: _____ Expiration: ____/____ CVC Code: _____ Billing Zip: _____				
First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA <input type="checkbox"/>
<input type="checkbox"/> Ship to Patient <input type="checkbox"/> Ship to Clinic	Rx Start Date:	Number of Refills:	Paid by: <input type="checkbox"/> Physician/Clinic <input type="checkbox"/> Patient	
Credit Card Number: _____ Expiration: ____/____ CVC Code: _____ Billing Zip: _____				
First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA <input type="checkbox"/>
<input type="checkbox"/> Ship to Patient <input type="checkbox"/> Ship to Clinic	Rx Start Date:	Number of Refills:	Paid by: <input type="checkbox"/> Physician/Clinic <input type="checkbox"/> Patient	
Credit Card Number: _____ Expiration: ____/____ CVC Code: _____ Billing Zip: _____				
First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA <input type="checkbox"/>
<input type="checkbox"/> Ship to Patient <input type="checkbox"/> Ship to Clinic	Rx Start Date:	Number of Refills:	Paid by: <input type="checkbox"/> Physician/Clinic <input type="checkbox"/> Patient	
Credit Card Number: _____ Expiration: ____/____ CVC Code: _____ Billing Zip: _____				

When shipping multiple patients' prescriptions together to a physician or clinic, please indicate "Earliest Date to be Administered" on order form Page 1 to determine ship date.
When shipping individual prescriptions directly to patients, indicate "Rx Start Date" for each on Page 2.

Current as of 10/15/15 v4

The pharmacy will plan for all orders to arrive by on day prior to these dates.